

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN7201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/21/2010
NAME OF PROVIDER OR SUPPLIER LAURELBROOK SANITARIUM			STREET ADDRESS, CITY, STATE, ZIP CODE 114 CAMPUS DRIVE DAYTON, TN 37321		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments During complaint investigation number 26676, 25926, 26161 and 26890 conducted on December 14 -21, 2010, at Laurelbrook Sanitarium, no deficiencies were cited in relation to the complaints under 1200-8-6, Standards for Nursing Homes.	N 000			

Division of Health Care Facilities

Heaven Hecht
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Asst Administrator
TITLE

(X6) DATE

1-7-11

STATE FORM

6899

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If continuation sheet 1 of 1